U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 28 March 2007

Case No. 2005-BLA-5868

In the Matter of:
M.N.,1 Widow of E.H.N., Deceased Miner
Claimant,

v.

STAR FIRE COALS, INC.
c/o HORIZONS NATURAL RESOURCES
Employer,
OLD REPUBLIC INSURANCE CO.
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest.

APPEARANCES:
Stephen A. Sanders, Esq. (For Claimant)
Prestonsburg, Kentucky

Alison C. Wells, Esq. (For Employer/Carrier)
Hazard, Kentucky

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

1 Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, (hereinafter referred to as "the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On May 12, 2005, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 42).[3] A formal hearing on this matter was conducted on July 26, 2006, in Hazard, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

Procedural History

M.N. ("Claimant") filed an application for benefits under the Act on April 1, 2002. (DX 3).[4] The Office of Workers' Compensation Programs (OCWP) made a preliminary determination that Claimant would not be entitled to benefits. (DX 24). On September 12, 2003, the District Director issued a Proposed Decision and Order denying benefits. (DX 26). The District Director found that E.H.N. ("Miner") had worked ten years in qualifying coal mine employment, that he did not have pneumoconiosis, and that he was not totally disabled by the disease. Claimant requested modification of that decision, submitting additional medical

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I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank,* 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia,* that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's exhibits, "EX" refers to the Employer's Exhibits, and "Tr" refers to the official transcript of this proceeding.

[4] The miner filed a claim on July 23, 1994, which was denied and administratively closed after no appeal was taken from a Decision and Order issued September 20, 1996. (DX 1).

evidence with this request. (DX 30). In response, the Employer submitted a medical opinion in support of its case. (DX 37). The District Director considered all of the new evidence and issued a Proposed Decision and Order Granting the Request for Modification. (DX 37). The Employer requested a formal hearing on this claim and it was transferred to the Office of the Administrative Law Judges on May 12, 2005. (DX 38; DX 42).

ISSUES

The issues in this case are:

1. Whether the Miner has pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment; and

3. Whether the Miner's death was due to pneumoconiosis.

(DX 39; Tr. 7). The issues as set forth in 18B of Form CM-1025, referred to this office with the claim, were raised for appellate purposes.

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

E.H.N. was born on April 13, 1931 and died on November 9, 2001. (DX 3; DX 11; Tr. 14). He married M.N., the claimant, on September 21, 1953. (DX 10). They remained married and lived together until Miner's death. Claimant has not remarried. (Tr. 10; Tr. 14). According to Claimant, Miner last engaged in coal mine employment in 1979, and his last position involved running a grader, a loader and a dozer. (Tr. 10). The documents of record support her testimony. (DX 6-8). Miner's work was all above ground on strip mines, in dusty conditions. (Tr. 10; Tr. 15). Claimant stated that her husband would return home from work each night covered with coal dust and sand. (Tr. 11).

Claimant alleged that her husband worked fifteen years in the mines and the parties stipulated that he had at least ten years of qualifying coal mine employment. (DX 6; Tr. 7). All of his coal mine work took place in Kentucky.

Claimant testified that her husband had breathing problems for years and struggled to breathe, even when walking short distances. (DX 12; Tr. 12). She stated that Miner coughed on a regular basis and had black sputum from coal dust. (Tr. 12). Her husband would stop and rest when walking from their house to the garage, a distance of approximately 25 feet. (Tr. 12). Claimant also testified that her husband smoked approximately one pack to one and one-half

packs of cigarettes per day for approximately forty-eight years. (Tr. 13; Tr. 15). Miner quit smoking the year he was diagnosed with cancer, in 2001. (DX 12; Tr. 14).

Length of Coal Mine Employment

Miner was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated and I find that, based on a review of Miner's employment records and Social Security Earnings Statement, he engaged in coal mine employment for at least ten years. (DX 6-8; Tr. 73).

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, not more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii).). §§ 725.414(a)(2)(ii); (a)(3)(ii); and (a)(3)(iii). Notwithstanding the limitations of § 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination provided by the Department of Labor shall not be counted as evidence submitted by the claimant under § 725.414. § 725.406(b).

Employer and Claimant have completed Black Lung Benefits Act Evidence Summary Forms. (EX 1; CX 1). Employer listed the medical report of Dr. Richard L. Naeye and the Death Certificate completed by Dr. John Gilbert as its initial medical opinion evidence. (DX 34; DX 11). Employer also listed as Autopsy evidence the report by Dr. S. Chan. (DX 13). Claimant listed two x-interpretations by Drs. Cole and Myers that were taken in 1990, which were both submitted with the living miner's claim. (DX 10). Claimant also submitted a pulmonary function study from 1994 and a medical report by Dr. Baker, introduced as part of Miner's claim, as well. (DX 1). As a second medical opinion, Claimant submitted Dr. Kahn's consulting report generated in 2004 (DX 30), and the pathology report by Dr. Chan. (DX 13). No blood gas studies were listed on either form. Both Claimant and Employer listed Miner's hospitalization and treatment notes from Hazard Appalachian Regional Hospital covering the period of January 2001 through the date of Miner's death on November 9, 2001. (DX 13). All of this evidence complies with the requisite quality standards of §§ 718.102 - 718.107 and the limitations of § 725.414(a)(3). Therefore, I admit all evidence Employer and Claimant have designated on their summary forms.

X-RAY REPORTS

Exhibit	Date of X-ray	Date of Reading	Physician/Qualifications	Interpretation
DX 1	12/18/90	1/14/91	Cole/B-Reader and BCR[5]	1/1
DX 1	12/18/90	4/02/90	Myers	½

PULMONARY FUNCTION STUDIES

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
DX 1 12/30/94	Good/ Good/Yes	63/ 64"	1.73	3.56	55	56.3%	No

NARRATIVE MEDICAL EVIDENCE

Claimant designated the examination report by Dr. Glen Baker, who saw Miner on December 30, 1994. (DX 1). Dr. Baker ordered an x-ray, pulmonary function study and blood gas study at the time of his exam. This doctor also considered a coal mining history of fifteen to sixteen years in strip mining and Miner's smoking habit of one pack of cigarettes per day for fifty-three years and still smoking at the time. The doctor recorded symptoms of sputum, wheezing, dyspnea, cough, and noted the patient's family and medical history. Based on this information, Dr. Baker diagnosed bronchitis, COPD with moderate obstructive defect and an infiltrate in the right upper lobe of his lung by x-ray. Dr. Baker attributed the bronchitis and COPD to cigarette smoking and coal dust exposure, thereby diagnosing legal pneumoconiosis. The physician believed Miner had a "moderate impairment" with decreased FEV_1. Dr. Baker provided no explanation for his diagnoses, other than to list "history of cough, sputum production and wheezing," and referred to "PFTS" and "chest x-ray."

The record contains voluminous notes and reports from the Harlan Appalachian Regional Hospital dating from January of 2001 through November 9, 2001, when Miner died. (DX 13).

[5] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979). "BCR" designates a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

These notes principally concern Miner's diagnosis of lung cancer, as revealed by several CT scans and x-rays. Physicians who were consulted and provided examining reports include Dr. B. Oladiran, Dr. P. I. Naryan, Dr. Hassan Ghazal, Dr. John Gilbert, Dr. Paneb Das, Dr. Joseph Florence, Dr. Viji Srinivasan, Dr. Srini Appakondu, and Dr. Firas Koura. The assessments from January through October list the patient's chronic obstructive pulmonary disease (COPD) and emphysema. A bronchial washing and bronchoscopy was performed in January of 2001, after which the samples revealed "nonsmall cell carcinoma." Coal Workers' Pneumoconiosis (CWP) is listed on some of the medical reports as part of the patient's "history." Dr. Florence listed also CWP at that time as part of his assessment, and stated that the patient's oxygen saturation was "currently good" on room air. Dr. Florence provided no explanation for his diagnosis and did not specifically treat the disease.

Later that month, Dr. Patel found a tumor in Miner's lungs, on x-ray, and also noted "fibrotic changes" in the right apex, but he did not mention anthracosis or pneumoconiosis. A few other doctors listed CWP as part of their assessment, but no doctor treated the patient for this disease or explained the basis for this diagnosis. Miner was treated for upper GI bleeding early in 2001 and advised "not to smoke." In October of 2001, Dr. Appakondu was consulted for the patient's shortness of breath, when he noted current treatment for pneumonia, and described eventual acute respiratory failure. Dr. Appakondu did not believe the source of the patient's shortness of breath was cardiac, in nature. However, this doctor also found hypertension and anemia, and recognized the diagnosis of lung cancer. On October 17, Miner was admitted for weakness and inability to eat and on October 24, was intubated for mechanical ventilation.

Dr. John Gilbert described the remaining days of Miner's final hospitalization and treatment:

> The patient was in acute respiratory failure secondary to COPD, CA [cancer] of the lung and left lower pneumonia with hypotension secondary to sepsis. The patent remained intubated and on the ventilator. A bronchoscopy was performed with washings and brushings under IV sedation. Chest x-ray showed marked improvement after the bronchoscopy. By October 27, 2001, the patient remained intubated, but was then on C-PAP with weaning process ongoing. Chest x-ray was improved and ABG's were good. By October 28, 2001 the patient was complaining of respiratory difficulty . . . The patient continued to be followed and managed by Dr. Koura and Dr. Srini. The patient developed tight expiratory sonorous rales with labored expiratory phase on October 28, 2001. He subsequently developed stridor secondary to laryngeal edema and was reintubated. The patient continues in ICU intubated and on the ventilator. Blood cultures came back positive for VRE. He was placed in isolation and was to have one to one nursing. He was once more anemic … and was transfused with two units of packed red blood cells … He was extubated on October 31, 2001 and placed on a aerosol mask at 40% … On November 2, 2001, the patient was once more complaining of smothering with O_2 still good at 95-96%. The family had requested more pain medication for the patient, so the Duragesic patch was increased to 75 mcg. CT scan of the chest showed a new right lung mass and bilateral effusions in additional to the left hilar mass and mediastinal

> lymphadenopathy … The patient was placed on Morphine drip for pain management. By November 5, 2001 the patient was once again extubated. He was alert and lucid at the time. He was continued on Morphine drip … and remained in ICU. The patient continued to be followed and managed by Dr. Koura. By November 8, 2001, the Morphine drip had been increased to 10mg per hour continuous drip. Vital signs were stable. O_2 saturations were showing 89% on 40% mask, so O_2 was increased to 50%. The patient's condition worsened throughout the day with him becoming more hypoxic. O_2 was increased with his condition continuing to worsen. He developed respiratory distress on evening of November 8, 2001 and as a last resort, bronchoscopy was performed by Dr. Koura for purpose of clearing airways and improving pulmonary toilet. The patient tolerated the procedure as well as possible, but his condition continued to worsen. At this point, comfort measures only were continued. The patient expired at 5:00 on November 9, 2001.

(DX 13, p. 114-115).

The Death Certificate was completed by Dr. Gilbert, the same doctor who had dictated the final hospitalization report. (DX 11). The cause of death was listed as "non-small CA of the lung with brain metastases."

Dr. Shiu-Keen Chan was the prosector who performed an autopsy of the chest, only, and completed his report on November 9, 2001. (DX 13, p. 109). Dr. Chan's Final Anatomical Diagnoses included: 1) Squamous cell carcinoma, moderately differentiated of both lungs; 2) Pleural effusions, bilateral; 3) Mild pleural adhesions, bilateral; 4) Emphysema, bilateral consistent with centriacinar type; 5) No evidence of coal worker's pneumoconiosis; 6) Bronchial pneumonia, bilateral; and 7) Chronic passive congestion lungs, bilateral. In his description of the Respiratory System, Dr. Chan reported a mass of about five cm in diameter on the left upper lobe and four nodules on left lobes of lung. He saw multiple gray-white nodules on the right lung measuring 1 to 1.5 cm in diameter. This pathologist's microscopic observations included emphysema in the left lung consistent with the centriacinar type, bronchial pneumonia and passive congestion. The tumors of both lungs showed squamous cell carcinoma. Dr. Chan noted that the "pleura and both lungs show mild deposition of black pigment." However, as he noted, above, he found no evidence of pneumoconiosis.

In a consulting report dated July 24, 2004, Dr. Jeffrey A. Kahn provided his opinion surrounding Miner's pulmonary condition and the cause of his death. (DX 30). This specialist, a board-certified pathologist, reviewed the twelve microscopic slides from the autopsy, Dr. Chan's autopsy report and the Death Certificate. Dr. Kahn reported finding severe pulmonary emphysema and broad areas of fibrosis. He also found "moderate quantities of coal dust present within the perivascular, perbronchial and septal connective tissues as well as within the walls of the terminal respiratory units where there is associated fibrous proliferation producing macule formation." He explained that coal macules "are the hallmark lesions of Coal Workers' Pneumoconiosis." This doctor also found silica, which he believed contributed to the development of Miner's chronic bronchitis present in the lung sections. He stated that the chronic bronchitis, along with the emphysema "manifested clinically as chronic obstructive

pulmonary disease," which he recognized as one of the diagnosed diseases. He added that coal dust and silica "have also been known to increase the risk of developing lung cancer." Finally, Dr. Kahn found acute bronchopneumonia, "an apparent pre-terminal condition, to which the development was contributed to by the lung cancer, emphysema, interstitial fibrosis, coal workers pneumoconiosis and chronic bronchitis." Dr. Kahn concluded that each of these diseases suffered by Miner "got multiplied by the effects of the other diseases present." In his words:

> The combination of the effects of each disease is not additive to the effects of the others, but rather is multiplicative and this combination of disease conditions culminated in hastening and producing Mr. N_____'s [name omitted] death. In this process, it is my medical opinion, which I state with a reasonable degree of medical certainty that Coal Workers' Pneumoconiosis significantly contributed to Mr. _____'s death.

(DX 30, p. 3).

Dr. Richard L. Naeye, also a board-certified pathologist, reviewed all medical information in Miner's file, including the hospitalization records during his final stay, the Autopsy Report, the 12 slides and the Death Certificate, and provided a consulting report dated October 9, 2004. (DX 34). Dr. Naeye also considered Miner's coal mining history and smoking history. His review of the lung tissue on the slides revealed abnormalities that included massive acute lobular pneumonia, large areas of poorly differentiated carcinoma, and large masses of hyalinized collagen without any associated black pigment, birefringent crystals, or any other evidence of occupational origin. He found no recent growth at the edge of the very old lesions and noted that these were "clearly not manifestations of complicated coal worker's pneumoconiosis." Dr. Naeye found only a "small amount of black pigment in the lung tissues," located at sites below the pleura, adjacent to small arteries and airways and in lymph nodes. He observed only a "birefringent crystal associated with the pigment." The doctor noted that the emphysema he saw varied from "very mild to moderately severe from one piece of lung tissue to another." This specialist concluded, as follows:

> The minimal findings required to make the diagnosis of coal workers' pneumoconiosis (CWP) are that black pigment with associated evidence of tissue damage be present in lung tissues. Such findings are not present in the lung tissues of E.H.N. [name omitted]. Being absent, CWP did not cause any disability or contribute in any way to this death. Neither U.S. nor European coal miners have been found to have an increased frequency of any form of lung cancer when cigarette smoking is taken into consideration.

Dr. Naeye then provided a detailed explanation for his opinion that exposure to coal mine dust does not increase the frequency of lung cancer, and attached scientific studies supporting this opinion.

DISCUSSION AND APPLICABLE LAW[6]

Because Claimant filed her application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. A surviving spouse is entitled to benefits if the miner died due to pneumoconiosis which arose out of coal mine employment. See 30 U.S.C. § 901; 20 CFR §§ 718.205 and 725.212(a)(3) (2003). In claims filed after January 1, 1982, death will be considered to be due to pneumoconiosis if (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis; (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) the presumption set forth at 20 CFR § 718.304 applies, i.e., an irrebuttable presumption that death was due to pneumoconiosis where there is medical evidence of complicated pneumoconiosis; but not if (4) the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 CFR § 718.205(c) (2003). The Sixth Circuit, in which this claim arises, has held that any condition that hastens the miner's death in any way is a substantially contributing cause of death. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995); *Brown v. Rock Creek Mining Corp*., 996 F.2d 812 (6th Cir. 1993). This principle has now been codified in the regulations at 20 CFR § 718.205(c)(5) (2003).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This

6 Because all of Miner's qualifying coal mine employment took place in Kentucky, the law of the Sixth Circuit applies to this claim. *Shupe v. Director, OWCP,*, 12 BLR 1-200, 1-202 (1989)(en banc).

definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Claimant designated two positive x-rays taken in 1990. One is by a B-reader and board-certified radiologist. Both x-rays were interpreted as positive for pneumoconiosis. As there is no contrary evidence, I find Claimant has established the existence of pneumoconiosis under § 718.202(a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon biopsy or autopsy evidence. The biopsy evidence in this case reveals only medical information surrounding Miner's lung cancer, after bronchoscopies and bronchial washings were performed. However, the autopsy evidence is highly probative to the existence of pneumoconiosis, as the prosector specifically found "no evidence of coal workers' pneumoconiosis." Here, the autopsy evidence is entitled to significant weight surrounding the existence of pneumoconiosis, as well as to the cause of death. Dr. Naeye's review of the autopsy report and slides supports Dr. Chan's finding of only mild deposition of black pigment in the lungs. Moreover, Dr. Chan's mention of "black pigment" is not sufficient, by itself, to establish the existence of pneumoconiosis. 20 C.F.R. § 718.202(a)(2). I find Dr. Naeye's opinion well-reasoned and documented and the most comprehensive of record, as it is based on all medical evidence submitted in support of the survivor's claim. *See Church v. Eastern Assoc. Coal Corp.*, 20 B.L.F. 1-8 (1996), *aff'd in relevant part on recon.*, 12 B.L.R. 1-51 (1997); *Scott v. Mason Coal Co.,* 14 BLR 1-37 (1990) (en banc recon.); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Burns v. Director, OWCP*, 7 BLR 1-597 (1984); *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984).

Dr. Kahn's review of the autopsy is less comprehensive than Dr. Naeye's report, and therefore entitled to less probative weight, notwithstanding their equal credentials as board-certified pathologists. Moreover, Dr. Naeye specifically addressed Dr. Kahn's opinion that Miner's exposure to coal dust may have led to his lung cancer, providing professional articles and associated reasons for refuting Dr. Kahn's belief. Therefore, assigning the greatest probative weight to the autopsy report and to Dr. Naeye's consulting opinion, I find that Claimant has failed to establish the existence of pneumoconiosis through biopsy or autopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Some of the doctors who saw Miner in the hospital listed coal worker's pneumoconiosis as one of Miner's several conditions. However, in many of these reports, the disease was listed as part of the patient's "history" as reported by the patient, himself. In other instances, the diagnosis CWP was never supported by an explanation or any evidence that the examining doctor or any other doctor treated Miner for that disease. Therefore, I find that these hospitalization and progress notes do not support a reasoned and documented finding of pneumoconiosis

Dr. Baker diagnosed pneumoconiosis in 1990 when he examined Miner. However, this opinion is over ten years old and entitled to little probative weight compared to the more recent and probative evidence now available. Further, Dr. Baker's opinion is not documented or reasoned, as Dr. Baker provided no basis for arriving at his conclusion that Miner suffered from pneumoconiosis other than to simply list three of the patient's symptoms and list "x-ray" and "PFTS." Dr. Baker failed to clearly explain how his physical findings and symptomatology were supportive of a finding of pneumoconiosis. Therefore, I accord his opinion little weight.

The remaining medical opinions of record that addressed the presence or absence of black lung have been discussed, above, with the autopsy evidence. The Employer has presented substantial evidence from well-qualified physicians that Miner did not suffer from pneumoconiosis at the time of his death. Relying principally on the opinions of Drs. Chan and Naeye, I find that Claimant has not shown, by a preponderance of the evidence, that he suffers from pneumoconiosis under subsection (a)(4).

Looking at the evidence as a whole under § 718.202, I find the autopsy evidence to be the most persuasive on the issue of pneumoconiosis. Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis and can be more probative to the existence of pneumoconiosis than x-rays. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985). *See also Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001), *and Energy West Mining Co. v. Director, OWCP [Jones]*, Case No. 03-9575 (10th Cir. July 9, 2004) (unpub.). As I have determined that the autopsy evidence shows no pneumoconiosis, looking at the totality of medical evidence, I find Claimant has failed to prove the existence of pneumoconiosis under § 718.202

Death Due to Pneumoconiosis:

Because I have found that pneumoconiosis was not present at the time of Miner's death, his death could not have been due to that disease. Assuming the presence of black lung, however, the evidence does not establish this necessary element for entitlement to benefits. Dr. Gilbert was Miner's last treating physician at the time of death and completed the final hospitalization report. As he was quite familiar with Miner's condition at that time, I assign great probative weight to his opinion on the Death Certificate that Miner's death was due to non-small CA of the lung with brain metastases. No other contributing condition was included on this certificate. While Dr. Chan did not specifically discuss a "cause of death," his anatomical diagnoses specifically excluded the existence of coal workers' pneumoconiosis, so that his opinion could not logically support a finding that this disease contributed or hastened Miner's death in any way. Dr. Kahn believed that coal workers' pneumoconiosis worked together with Miner's other conditions to contribute to his lung cancer that eventually caused Miner's death. However, Dr. Naeye's more reasoned opinion provides a sufficient basis to disprove Dr. Kahn's opinion, stating that Miner's exposure to coal dust did not contribute to his cancer and that the autopsy slides did not reveal sufficient coal macules to diagnose pneumoconiosis. Therefore, assigning the greatest probative weight to the opinions by Drs. Gilbert, Chan, and Naeye, I find that Claimant cannot show Miner's death was due to pneumoconiosis as required under 20 CFR § 718.205(c) (2003).

Entitlement

Claimant, M.N., has failed to prove, by a preponderance of the evidence, that Miner had pneumoconiosis or that his was death due to pneumoconiosis. Therefore, Mrs. N. is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that M.N.'s claim for benefits is DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).